Essex County Schools of Technology
OFFICE OF STUDENT-RELATED SERVICES

PARENTS MEDICAL CHECKLIST: Please Read Carefully!

PLEASE ENSURE ALL DOCUMENTS (COPY OF IMMUNIZATION AND A COMPLETED PHYSICAL FORM) ARE COMPLETELY FILLED BY THE PARENT/GUARDIAN AND CHILD'S DOCTOR! ***Fill out forms completely and in PEN (not pencil)***

- **School Nurses will be present at the respective schools to receive documentation**
- **All Medical Documents MUST be received by June 15th, 2024**

Newark Tech Campus	Donald M. Payne, Sr. Campus	West Caldwell Tech Campus
91 West Market St, Newark, 07103	*498-544 West Market St, Newark, NJ 07107*	*620 Passaic Ave, West Caldwell, NJ 07006*
Ms. Carolina Cabral, RN, BSN	Ms. Dionne Pace, RN, BSN, CSN	Ms. Bonnie Rogers, RN, BSN, CSN
CCabral@essextech.org	DPace@essextech.org	BRogers@essextech.org
	Ms. Amanda Gordon, RN	
	AGordon@essextech.org	

- Don't wait; make appointments now with your child's doctor. Your child will be **EXCLUDED** from school if his/her medical file is incomplete!
- Make certain **doctor signs, stamps and dates** the physical form before you leave his/her Office *(*Physicals are only effective for one (1) year from the date of the physical)*. For the Physical Examination Form, the doctor needs to sign page 1 and page 2 in 2 places
- Failure to provide a completed physical will result in exclusion from gym/sports/field trips. Exclusion from the gym will negatively impact the student's overall grade. A copy of the immunization and Physical Form must be completed
- Request that your child's 8th-grade school send the student's original health record to the receiving school
- If your child wears eyeglasses or contacts, please visit the eye doctor before school begins. Remind your child that caring for their contacts is their responsibility (always carry a spare contact case and solution)
- If your child uses an *inhaler, the **Asthma Treatment Plan** form must be signed by your child's doctor and parent/guardian. If your child uses an *EPI Pen, the **Food/Allergy Anaphylaxis Action Plan** form must be signed by your child's doctor and parent/guardian. **The inhaler or EpiPen MUST accompany your child on ALL field trips/sport events.** Please provide a spare inhaler or EpiPen pack for the medical office. **Incomplete medical files will mean that your child will NOT be allowed to travel on Field Trips OR take Gym.** Recommendations are **effective for one (1) school year ONLY and must be renewed ANNUALLY**
- Encourage your child to keep spare clothing on hand @ school in case of emergencies
- If your child suffers from menstrual cramps. Have her take pain medication before coming to school (or have the doctor complete the Administration of Medication form provided in this packet and supply the medical office with the medication). Students shouldn't miss class time due to this condition. In addition, if your child is taking medication or you allow your child to be given medication by the nurse the Administration of Medication form must be completed by the doctor
- Remember to update the school nurses each time your child receives an immunization (booster shot)
- Always have someone available to pick your child up from school, should the need arise
- Medical notes excusing an absence need to be turned in the day the student returns to school
- Any assistive device (i.e., crutches, ankles brace, arm sling, etc.) requires a doctor's order/note
- **If your child has a special diagnosis (high blood pressure, diabetes, etc.) notify the medical office BEFORE the School year begins**
- Return all calls from the school nurses as soon as possible, contact information is listed at the top of this document

Essex County Vocational Technical Schools
BOARD OF EDUCATION

PARENTS:

*Previous School:*_____

*School Doctor will be here on:*_____

NOTICE REGARDING PHYSICALS

Due to change in the New Jersey Administrative Code (N.J.A.C. 6A:16-22) "each student medical examination shall be conducted at the medical home (student's family physician or healthcare provider) of the student." For example, the student's physician or nurse practitioner/clinical nurse specialist may be acceptable.

If a student does not have a medical home (doctor), the school physician will perform the student medical examination in a district school health office, **after the parent/guardian signs the form that they do not have a family physician or healthcare provider.**

_____ _____
Student's Name (Print Name) Grade/ID Number

(check one)

_____ we will provide a physical from our family physician or health care provider.

_____ we do not have a medical home physician and will need a physical exam from the district.

(check one)

_____ does your child have health insurance.

_____ if not, would you be interested in having the school nurse provide information regarding the New Jersey State insurance plan?

_____
Parent/Guardian Signature

_____
Date

LEROY F. SMITH, JR. PUBLIC SAFETY BUILDING
60 NELSON PLACE, 1 NORTH, NEWARK, NJ 07102 -TELEPHONE (973) 412-2050 - FAX (973) 242-2453
www.essextech.org

This form should be placed into the athlete's medical file and should *not* be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another History Form.

PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, non-binary, or another gender): _____

Have you had COVID-19? (check one): ☐ Y ☐ N

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N If yes, have you had: ☐ One shot ☐ Two shots ☐ Three shots ☐ Booster date(s) _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Unsure**	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		

MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease? (Unsure)		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		

MENSTRUAL QUESTIONS	N/A	Yes	No
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. **Consider additional questions on more sensitive issues**
   - **Do you feel stressed out or under a lot of pressure?**
   - **Do you ever feel sad, hopeless, depressed, or anxious?**
   - **Do you feel safe at your home or residence?**
   - **Have you ever tried cigarettes, chewing tobacco, snuff, or dip?**
   - **During the past 30 days, did you use chewing tobacco, snuff, or dip?**
   - **Do you drink alcohol or use any other drugs?**
   - **Have you ever taken anabolic steroids or used any other performance supplement?**
   - **Have you ever taken any supplements to help you gain or lose weight or improve your performance?**
   - **Do you wear a seat belt, use a helmet, and use condoms?**
2. **Consider reviewing questions on cardiovascular symptoms (questions 5–14).**

EXAMINATION		
Height Weight	☐ Male ☐ Female	
BP / (/) Pulse	Vision R 20/ L 20/	Corrected ☐ Y ☐ N
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type)_____ Date of exam _____

Address _____ Phone _____

Signature of physician, APN, PA _____

HE0503 9-2681/0410

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	**No**
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

_____

_____

_____

_____

_____

Please indicate if you have ever had any of the following.

	Yes	**No**
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____
- Reason _____

Recommendations _____

_____

_____

_____

_____

_____

EMERGENCY INFORMATION

Allergies _____

_____

_____

_____

_____

_____

Other information _____

_____

_____

_____

_____

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on _____
(Date)

Approved _____ Not Approved _____

Signature: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

**NOTE: (2) PHYSICIAN SIGNATURES ARE REQUIRED FOR THE SCHOOL DR TO APPROVE

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

Completed Cardiac Assessment Professional Development Module

Date _____ Signature _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

Essex County Schools of Technology
Office of Student-Related Services

PERMISSION FOR ADMINISTRATION OF MEDICATION BY SCHOOL NURSE

NO MEDICATIONS ARE TO BE BROUGHT INTO SCHOOL
WITHOUT SUBMITTING THIS FORM.
FORM MUST BE SIGNED BY YOUR CHILD'S DOCTOR.

MEDICATION DISPENSING FORM-PARENT/GUARDIAN

I request that the enclosed medication, in the original container, be administered to _____ (student's name)
I give the school nurse permission to contact the physician and/or pharmacist with any questions concerning the medication.

Student's Age_____ Grade_____ School _____

Name and Strength of Medication_____

Time of Administration_____Dosage_____ Prescription_____ Non-Prescription_____

Reason for Medication_____

Effective dates: from_____20____ to _____20____

_____ _____ _____ _____
Parent/Guardian Signature Date Home Telephone Work Telephone

MEDICATION FORM-PHYSICIAN

Patient's Name_____

Medication: Name, Strength, Dosage, Time of Administration:_____

_____

Purpose of Medication:_____

_____ _____
Physician's Name Physician's Signature

_____ _____
Physician's Stamp (should include address and phone#) Date

PERMISSION FOR SELF-ADMINISTRATION OF MEDICATION BY STUDENTS LISTED BELOW
PHYSICIAN'S FORM FOR EMERGENCY/SELF-ADMINISTERED MEDICATION

It is essential that _____(student's name) be permitted to carry and administer the following medication for the purpose of treating _____(diagnosis). This should be done under the supervision of the school nurse whenever possible. In the case of an emergency, or if the school nurse is not in the building, I have instructed this patient in the procedure for administration of this medication and find him/her competent to administer the medication.

Medication dosage and time of administration:_____

_____ _____
Physician's name Physician's Signature

_____ _____
Physician's Stamp (should include address and phone#) Date

Date rec'd (office use)_____

Essex County Schools of Technology
Office of Student-Related Services

ATHLETIC SPORTS SIGN-OFF

Please Complete & Return to the Medical Office

Student's Previous School _____

Student's Name_____ Grade_____ DOB_____

Address _____

City/State/Zip _____

Home Phone #_____

(1) Parent/Guardian's Name _____ (Relation) _____

Phone # _____

(2) Parent/Guardian's Name_____ (Relation)_____

Phone #_____

Please provide Email where you can receive notifications: _____

Circle any sport(s) your child might be interested in:

Girls' Soccer / Boys' Soccer / Cross Country / Girls' Volleyball / Boys' Volleyball / Girls' Basketball / Boys' Basketball / Softball / Baseball/ Track & Field / Cheerleading / Bowling

Give bottom portion to **8th grade school nurse**

Please ask that your child's 8th grade school nurse send the student's original health record to the High School nurses @:

Essex County Schools of Technology
Donald M. Payne, Sr. Campus
498-544 W. Market St.
Newark, NJ 07107
ATTENTION: Medical Office

Essex County Schools of Technology
Newark Tech Campus
91 W. Market St.
Newark, NJ 07107
ATTENTION: Medical Office

Essex County Schools of Technology
West Caldwell Tech Campus
620 Passaic Ave
West Caldwell, NJ 07006
ATTENTION: Medical Office

Dear School Nurse:

_____ [Student's name (please print)] will be attending _____ **Campus** for the 20__ /20__ school year. At the end of the current school year. Please send the original A45/immunization/medical record to the above address.

Parent's Signature _____ Date _____

American Lung Association.

My Asthma Action Plan
For Home and School

Name: _____ DOB: ____ / ____ / _____

Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list): _____

Peak Flow Meter Personal Best: _____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night
Peak Flow Meter _____ (more than 80% of personal best)

Flu Vaccine—Date received: _____ Next flu vaccine due: _____ COVID19 vaccine—Date received: _____

Control Medicine(s)	Medicine	How much to take	When and how often to take it	Take at
				☐ Home ☐ School
				☐ Home ☐ School

Physical Activity ☐ Use Albuterol/Levalbuterol ____ puffs, 15 minutes before activity ☐ with all activity ☐ when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or tight chest – Problems working or playing – Wake at night
Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐ Albuterol/Levalbuterol ____ puffs, every 20 minutes for up to 4 hours as needed
Control Medicine(s) ☐ Continue Green Zone medicines
☐ Add _____ ☐ Change to _____

You should feel better within 20-60 minutes of the quick-relief treatment. If you are getting worse or are in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping
Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐ Albuterol/Levalbuterol ____ puffs, _____ (how frequently)

Call 911 immediately if the following danger signs are present:
- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

School Staff: Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms.
The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to "Take at School".

☐ Both the Healthcare Provider and the Parent/Guardian feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Healthcare Provider
Name _____ Date _____ Phone (____) ____ - _____ Signature _____

PHYSICIAN STAMP

Parent/Guardian
☐ I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.
☐ I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.
Name _____ Date _____ Phone (____) ____ - _____ Signature _____

School Nurse
☐ The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.
Name _____ Date _____ Phone (____) ____ - _____ Signature _____

Please send a signed copy back to the provider listed above.

1-800-LUNGUSA | Lung.org

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

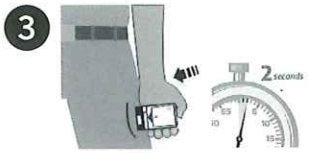
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FARE Food Allergy Research & Education

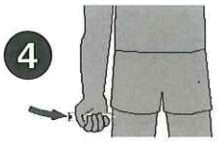
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO



1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.

HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN



1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

SEIZURE ACTION PLAN FOR

_____ (INSERT NAME HERE)

Attach Student Photo

ABOUT

Name _____ Date of Birth _____

Doctors Name _____ Phone _____

Emergency Contact Name _____ Phone _____

Emergency Contact Name _____ Phone _____

Seizure Type/Name: _____

What Happens: _____

How Long It Lasts: _____

How Often: _____

Seizure Triggers:

☐ Missed Medicine ☐ Lack of Sleep ☐ Emotional Stress ☐ Physical Stress ☐ Missing meals

☐ Alcohol/Drugs ☐ Flashing Lights ☐ Menstrual Cycle ☐ Illness with high fever

☐ Response to specific food, or excess caffeine Specify: _____ ☐ Other Specify: _____

DAILY TREATMENT PLAN

Seizure Medicine(s)

Name	How Much	How Often/When

Additional Treatment/Care: (i.e.: diet, sleep, devices etc.)

CAUTION–STEP UP TREATMENT

Symptoms that signal a seizure may be coming on and additional treatment may be needed:

☐ Headache ☐ Staring Spells ☐ Confusion ☐ Dizziness ☐ Change in Vision/Auras

☐ Sudden Feeling of Fear or Anxiety ☐ Other Specify: _____

Additional Treatment:

☐ Continue Daily Treatment Plan

- If missed medicine, give prescribed dose from above ASAP.
- Do not give a double dose or give meds closer than 6 hours apart.

☐ Change to: _____ How Much: _____ How Often/When: _____

☐ Add: _____ How Much: _____ How Often/When: _____

☐ Other Treatments/Care: (i.e.: sleep, devices): _____

SEIZURE ACTION PLAN

DANGER–GET HELP NOW

Follow Seizure First Aid Below

☐ Find adult trained on rescue medication:

Name: _____ Number: _____

☐ Record Duration and time of each seizure(s)

☐ Call 911 if:

- Child has a convulsive seizures lasting more than ___ minutes
- Child has repeated seizures without regaining consciousness
- Child is injured or has diabetes
- Child is having breathing difficulty

When EMS arrives, a medical provider will perform an individual assessment to determine appropriate next steps.

Rescue Therapy:

☐ Rescue therapy provided according to physician's order:

_____

_____

POST SEIZURE RECOVERY

Typical Behaviors / Needs After Seizure:

☐ Headache ☐ Drowsiness / Sleep ☐ Nausea ☐ Aggression ☐ Confusion / Wandering ☐ Blank Staring

☐ Other Specify: _____

Reviewed / Approved by:

_____

Physician Signature Date

_____

Parent / Guardian Signature Date

SEIZURE FIRST AID

Image adapted with permission from the Epilepsy Foundation of America

LEARN MORE AND GET A DOWNLOADABLE VERSION OF THIS ACTION PLAN AT:

Child Neurology FOUNDATION
Creating a Community of Support
childneurologyfoundation.org/sudep

Danny Did FOUNDATION
dannydid.org

EPILEPSY FOUNDATION
SUDEP INSTITUTE
epilepsy.com/sudep-institute